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ABSTRACT

The age at which women marry and bear chldren can influence their health and well-being and that of their chi dren. This fact is at the heart of the analysis contained in this document which was a result of a study of the World Fertility Survey (WFS) and other data pertaining to global demographics. The document is comprised of seven sets of graphs which are intended to provide information on various statistical aspects of family planning. These include schematic representations of: (1) completed fertility of women aged 45-49 years by age at first marriage (in all of the WFS countries); (2) infant, toddler, and child mortality by age of mother at birth (in selected WFS countries); (3) infant mortality by length of birth interval (in five major regions of the world); (4) infant mortality by birth order (in selected WFS countries); (5) infant mortality by mother's education (in selected WFS countries); (6) infant mortality by literacy of parents (in selected WFS countries); and (7) the practice of contraception by child loss among women with four to six children. (TW)

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FAMILY PLANNING AND THE WELL-BEING OF WOMEN AND CHILDREN

An analysis of World Fertility Survey and other data prepared for IPPF by Acsadi Associates, Consultants in Demography and Statistics.

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FAMILY PLANNING AND THE WELL-BEING OF WOMEN AND CHILDREN

The age at which women marry and bear children influences their health and well being and that of their children. The earlier she marries following physiological maturity, other things being equal, the more children the woman will have at the end of her reproductive years (figure 1). Later marriage combined with family planning promises women better health and smaller families.

If women marry early and do not postpone the first birth, and if they continue childbearing beyond the prime reproductive ages, they are likely to experience child loss. Infants and children up to age 4 years whose mothers are under age 20 or over 40 at their birth have higher mortality rates than do those born to women 20-39 years old (figure 2). Child health may be greatly enhanced by proper spacing; i.e. by maintaining an interval of two to three years between consecutive births, although an interval of four or more years would, in most countries, bring optimal results (figures 3A and 3B).

Infant mortality tends to be high among the first born compared to that among second and third order births, particularly where women marry and have their first child at an early age. This pattern is less conspicuous or non-existent where childbearing is begun at more mature ages. High order births tend generally to have poor survival chances (figure 4).

In these countries, early marriage is incompatible with extended formal education, yet the less education a woman has, the less chance her children have of surviving infancy (figure 5). And infant mortality rates tend to be highest in countries where the age of women at first marriage or union is lowest. Literate parents provide infants with better survival chances than do illiterate parents, and mother's literacy has a greater positive effect than father's ability to read and write (figure 6). Investments in the education of women, as well as men, would yield many social, health and other benefits.

Among multiparous women (with 4-6 births), contraception is practised more widely by those who have not experienced child loss than by those who have, but having had a child die is less a deterrent to contraceptive use in countries where family planning is relatively wide-spread than in those where the practice is less common (figure 7). The reduction of early child mortality would facilitate the acceptance of family planning, among other things.

Notes to the Figures

The following information is intended to facilitate understanding of the accompanying figures.

1. Figures 1 and 3B show data relevant to the five developing IPPF regions. The regional data are weighted averages of national figures obtained by the World Fertility Survey (WFS) in its participating countries. All other figures depict data from selected WFS countries. The selected countries are named on Figures 5 and 6. On Figures 2, 3B 4 and 7, the selected countries can be identified by code numbers, as follows:

Code	Country	Code	Country
1	Kenya	30	Bangladesh
2	Lesotho	31	Nepal
3	Nigeria	32	Pakistan
4	Senegal	33	Sri Lanka
10	Egypt	40	Colombia
11	Jordan	41	Costa Rica
12	Mauritania	42	Dominican Rep.
13	Sudan (North)	43	Guyana
14	Syria	44	Haiti
15	Tunisia	45	Jamaica
16	Yemen Arab Rep.	46	Mexico
		47	Panama
20	Fiji	48	Paraguay
21	Indonesia	49	Peru
22	Korea, Rep. of	50	Trinidad & Tobago
23	Malaysia	51	Venezuela
24	Philippines		
25	Thailand		

2. AGE AT MARRIAGE is the age at which the woman is first married including, for the Africa and the Western Hemisphere regions, the age at which she first enters a non-formal union. Where child marriages are common, as in some countries of the Indian Ocean region, the age referred to is that at which the woman first went to live with her husband.

3. INFANT MORTALITY is the number of infant deaths under age one year in a given calendar year per 1000 live births in that same year.

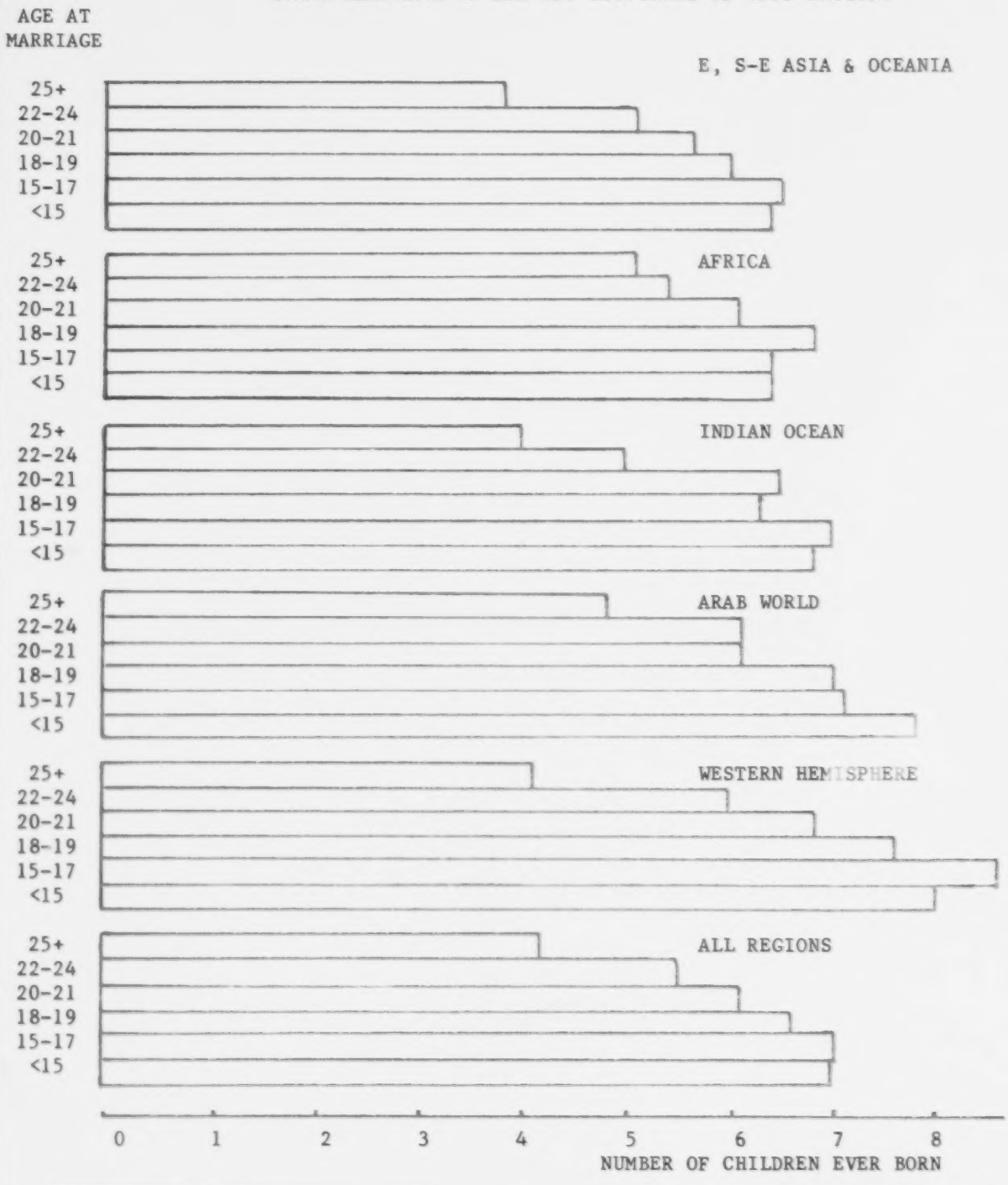
4. TODDLER MORTALITY is the number of deaths to one year old children in a given year per 1000 children of this age alive during the same year.

5. CHILD MORTALITY is the number of deaths to children aged 2-4 years in a given year per 1000 of the average number of children of these ages alive during the same year.

6. INTER-BIRTH INTERVAL is the number of years that elapse between births that occur consecutively to the same woman.

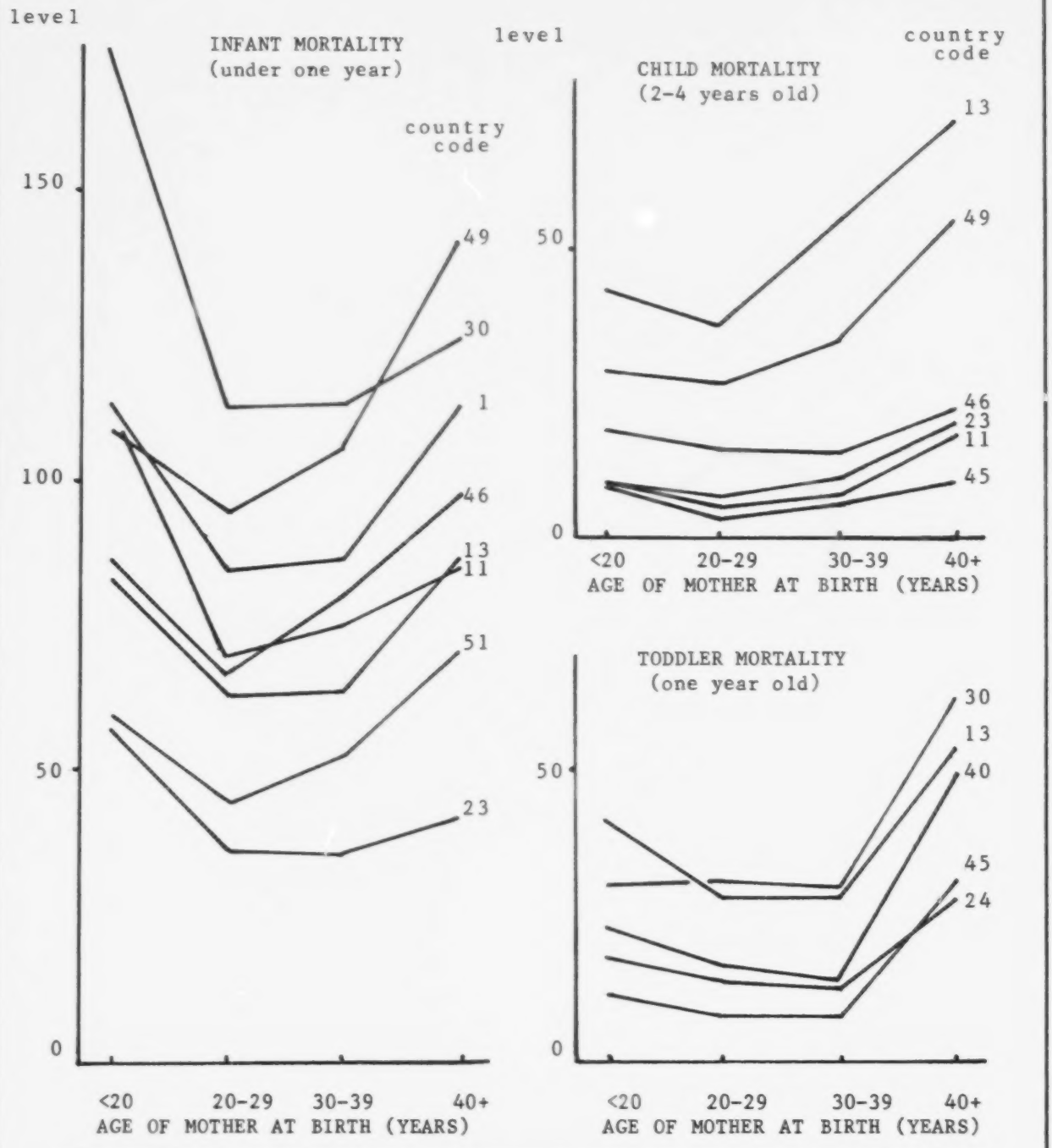
7. ORDER OF BIRTH (parity) denotes the numerical position (i.e., first, second, etc.) of a birth among all children born alive to a woman.

FIGURE 1. COMPLETED FERTILITY OF WOMEN AGED 45-49 YEARS BY AGE AT FIRST MARRIAGE IN THE WFS COUNTRIES OF IPPF REGIONS



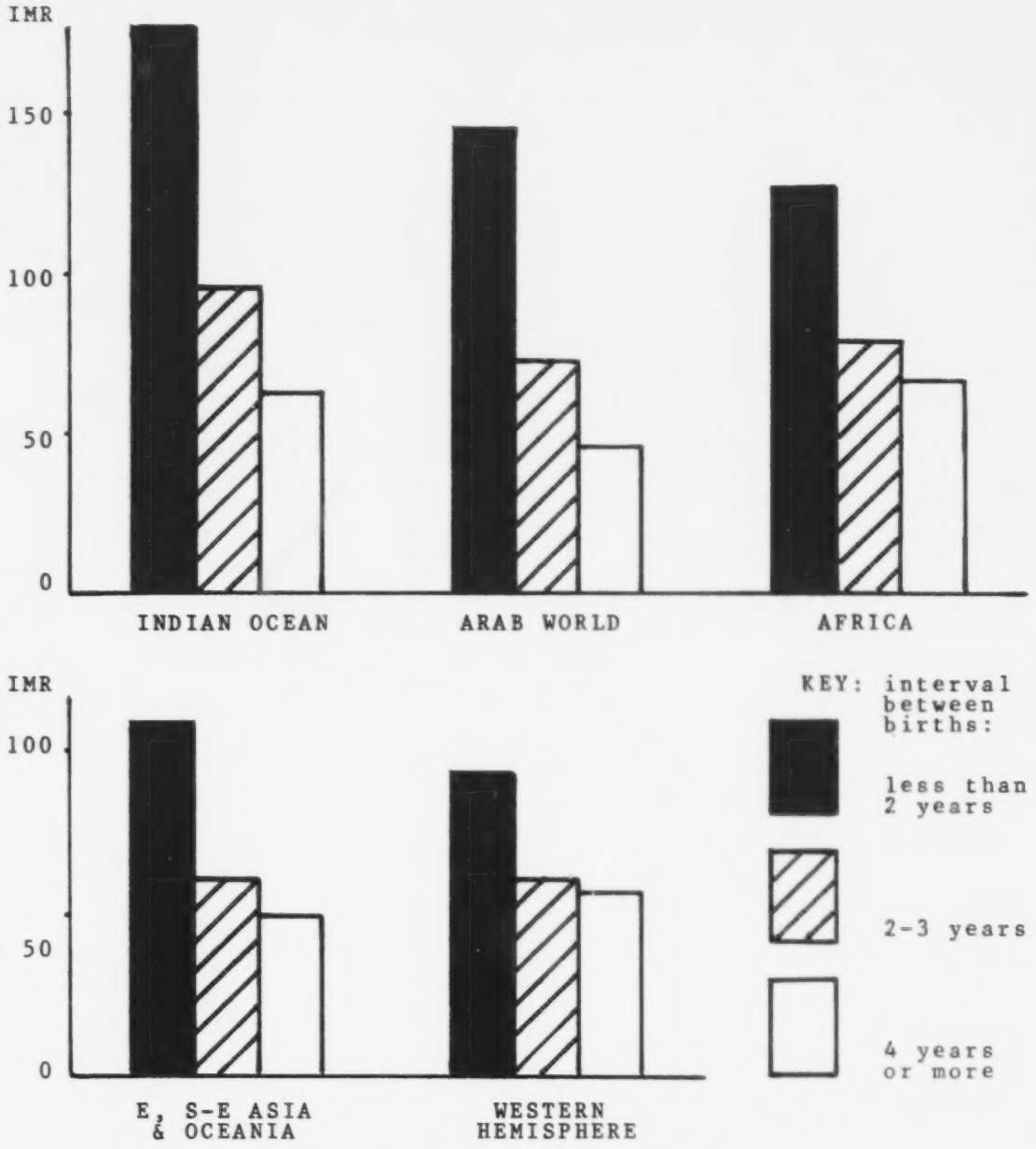
The younger the woman is at first marriage or union following physiological maturity, other things being equal, the more children she will have at the end of her reproductive years. However, marriage at a very early age (in most countries less than 15 or 16 years) may bring temporary infecundity and somewhat reduced completed family size. Early marriage without efficient family planning contributes to high fertility.

FIGURE 2. INFANT, TODDLER AND CHILD MORTALITY BY AGE OF MOTHER AT BIRTH: SELECTED WFS COUNTRIES



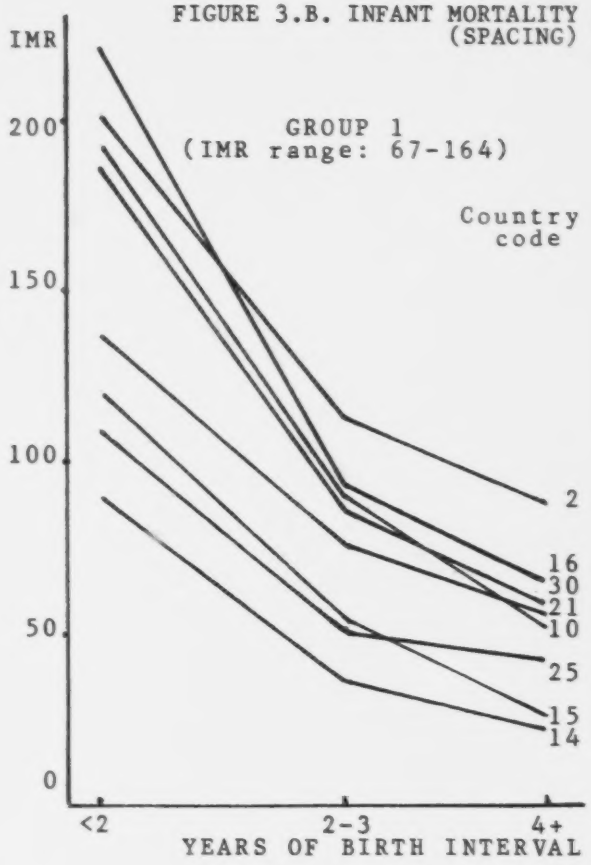
Mortality is generally higher among infants born to women aged under 20 and over 40 than among babies born to mothers aged 20-39. Survival prospects continue to be poor for these babies even after they become toddlers and reach ages 2-4. Hence, mortality by mother's age usually assumes a "U" shaped curve. Family planning to postpone the first births to a later age and to eliminate late childbearing would greatly reduce child loss in many countries.

FIGURE 3.A. INFANT MORTALITY (IMR) BY LENGTH OF BIRTH INTERVAL (SPACING) IN THE WFS COUNTRIES OF IPPF REGIONS



In each region, infants born at short intervals have considerably higher mortality than better (longer) spaced children. Traditional birth spacing of several years between consecutive births has a beneficial effect on the health of women and their children, and reduces infant mortality. But the beneficial effect of spacing on infant mortality also depends on the level of development (including that of health services) as it can be seen from Figure 3.B.

FIGURE 3.B. INFANT MORTALITY (IMR) BY LENGTH OF BIRTH INTERVAL (SPACING) IN SELECTED WFS COUNTRIES

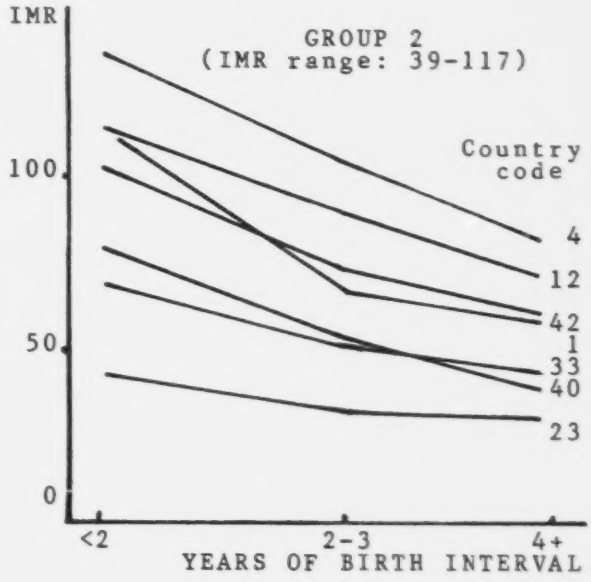


Favourable conditions as to mother's age at first marriage and at the birth, education and, in general, the level of development and health services in a particular country may modify the impact of spacing.

The detrimental effect of short spacing (less than two years) is most striking in the first group, which is characterized by high infant mortality. IMR drops first rapidly, then somewhat slower with the lengthening of birth intervals. Short spacing is one of the main causes of high infant mortality in these countries; its elimination and the reinstatement of proper spacing should drastically reduce infant mortality.

In Group 2 (where IMRs are moderate) the beneficial effect of spacing is proportionate to the length of birth intervals; longer spacing should contribute to further reduction of infant mortality.

In Group 3 (where IMRs are relatively low) the difference between mortality of infants born after shorter or longer spacing is smaller but the detrimental effect of short spacing on child survival is clearly demonstrated.



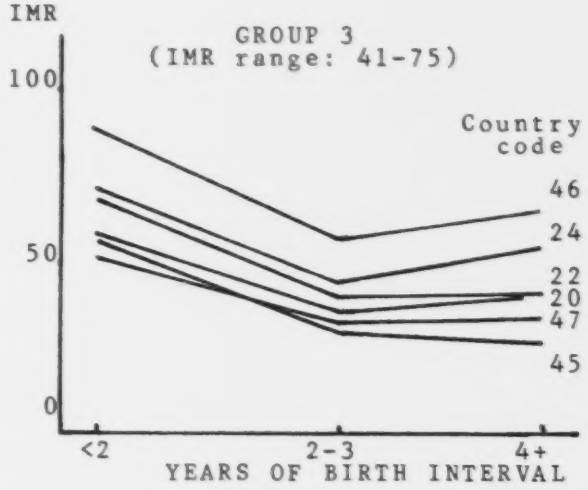
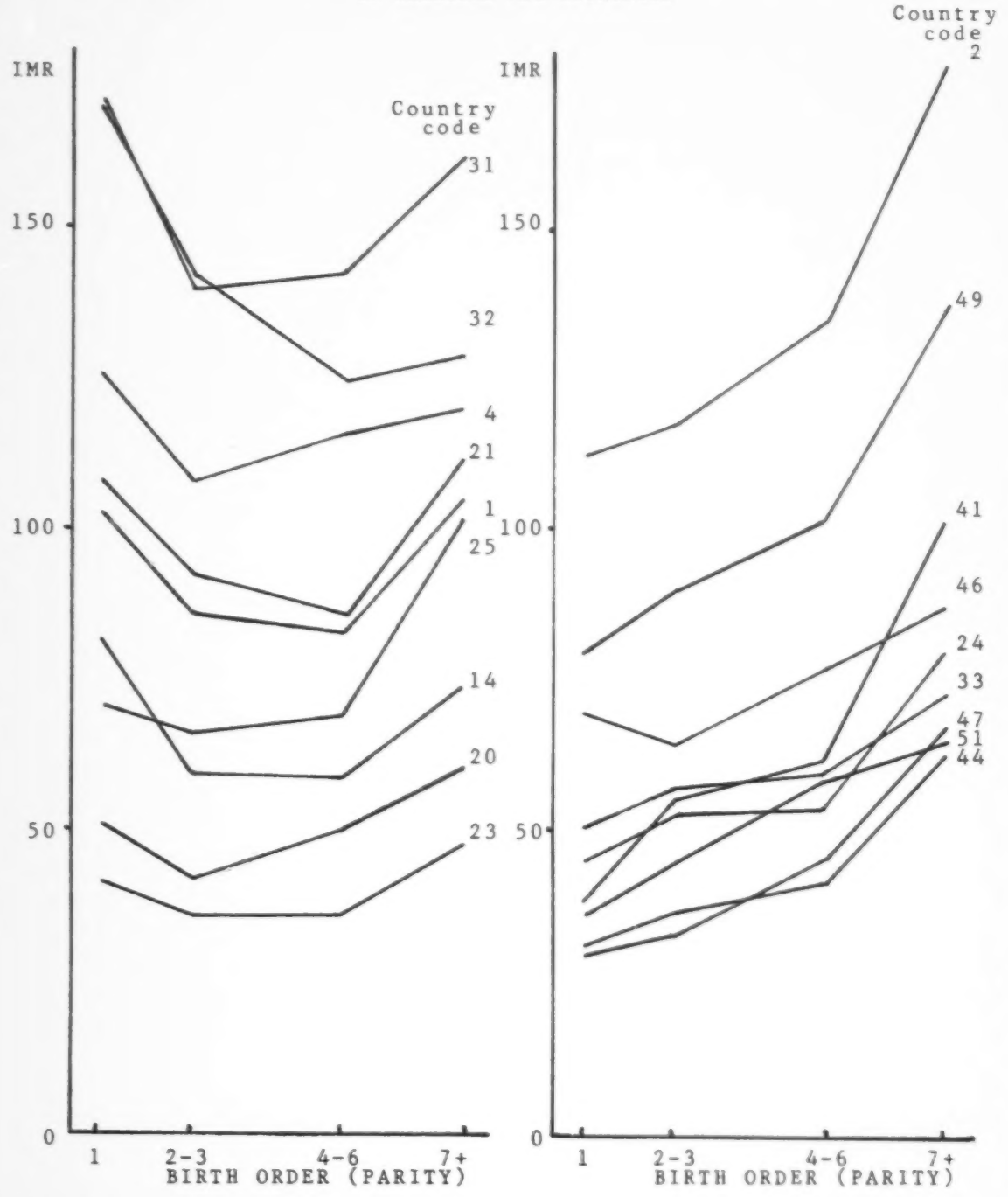
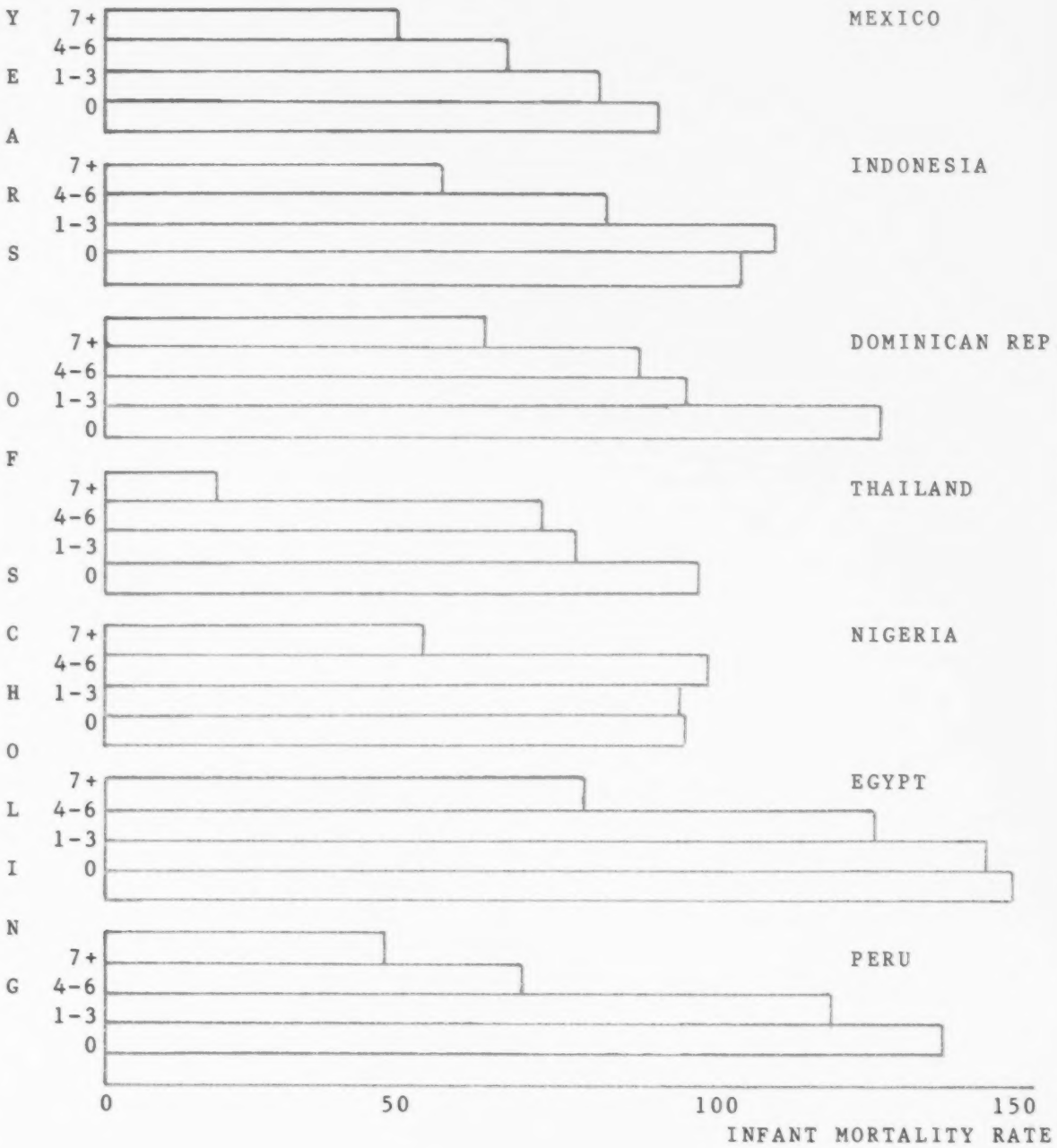


FIGURE 4. INFANT MORTALITY (IMR) BY BIRTH ORDER (PARITY)
IN SELECTED WFS COUNTRIES



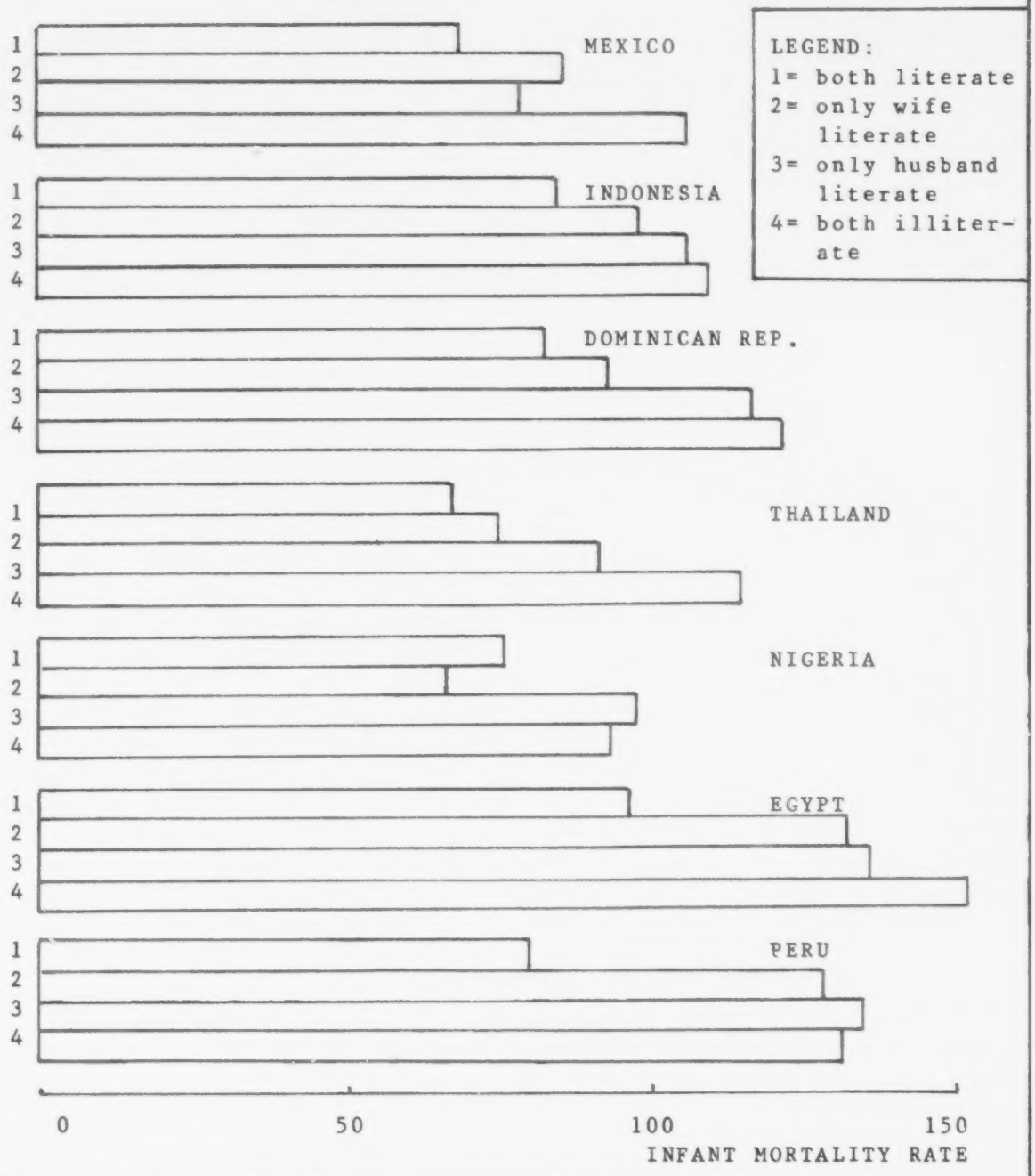
In many countries, mainly where women marry and have their first child at an early age, infant mortality among the first born is high in comparison to that of second and third order births. There is, however, a turning point between fourth and six parity, after which the chances of survival decrease as birth order rises. In other countries, where child-bearing begins later, infant mortality increases with each parity. High order births have relatively poor survival chances in both groups.

FIGURE 5. INFANT MORTALITY BY MOTHER'S EDUCATION
IN SELECTED WFS COUNTRIES



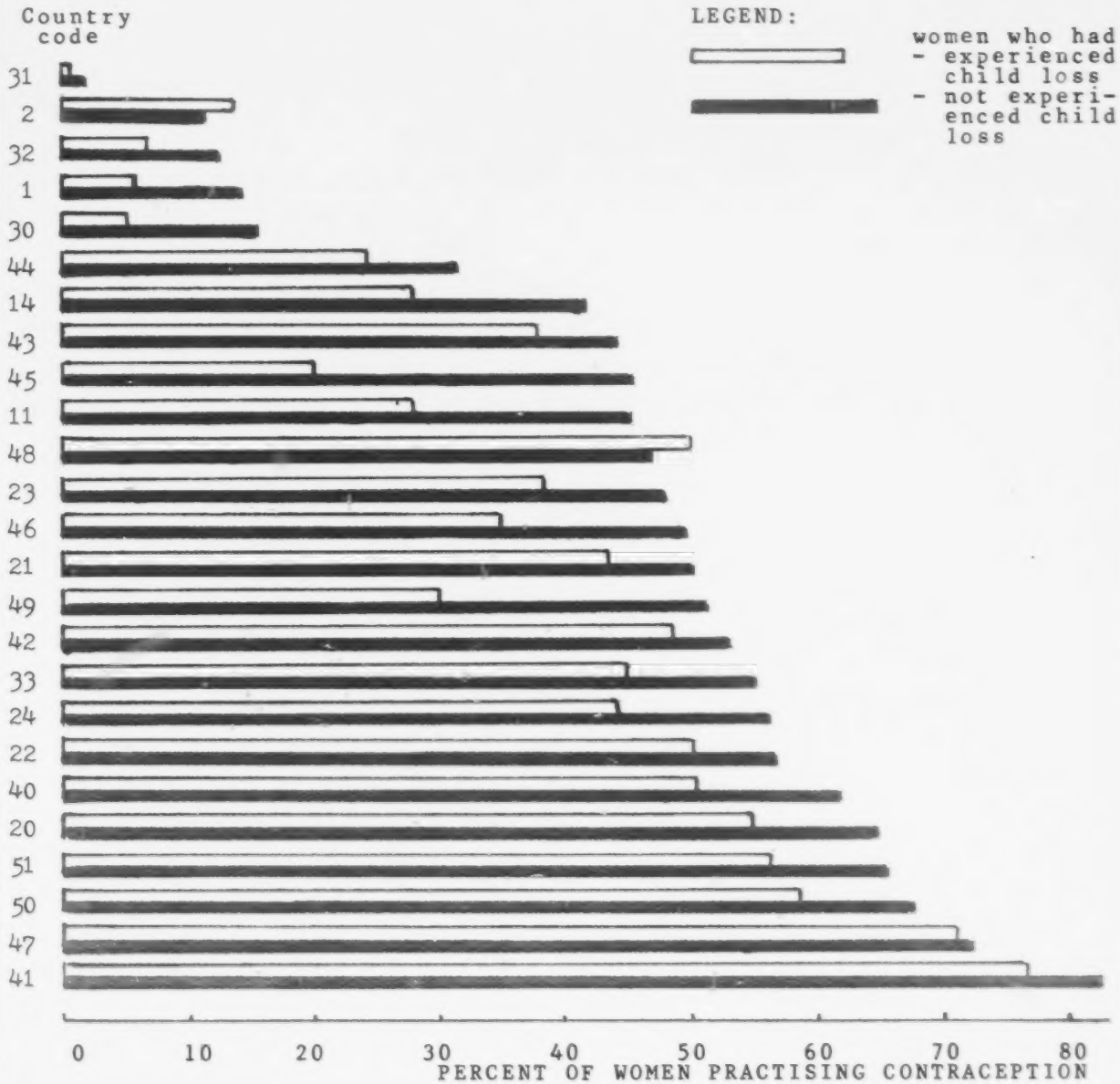
The more education a woman has, the higher the probability that her children will survive infancy. These chances may be greatly improved by as little as 1-3 or 4-6 years of schooling (Dominican Republic and Peru, respectively), or as many as seven years or more may be required (Thailand, Nigeria, Egypt). In some other countries the improvement is gradual (e.g. Mexico). Though the effect of mother's education differs among countries, its contribution to child survival is incontestable.

FIGURE 6. INFANT MORTALITY BY LITERACY OF PARENTS
IN SELECTED WFS COUNTRIES



Literate parents provide infants with a better chance of survival than is the case where one or both parents are illiterate. Mother's ability to read and write is generally a more important factor than father's literacy in ensuring survival of infants (see, for examples, data for Nigeria, Thailand and the Dominican Republic). From the viewpoint of reducing infant mortality, literacy of both parents, particularly that of mothers, should be vigorously promoted.

FIGURE 7. PRACTICE OF CONTRACEPTION BY CHILD LOSS AMONG WOMEN WITH 4-6 CHILDREN IN SELECTED WFS COUNTRIES



Among multiparous women (with 4-6 births), contraception is practised more widely by those who have not experienced child loss than those who have. However, experience of child death appears to be less of a deterrent in countries where family planning is relatively diffuse (41, 47) and/or infant mortality is relatively low (48). The reduction of early mortality of children would, inter alia, facilitate the acceptance of family planning.